

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1.
 - a. Whether there should be additional reimbursement for date of service 3-26-01.
 - b. The request was received on 3-23-02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA
 - c. EOBs and Example EOBs
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Response to a Request for Dispute Resolution
 - b. HCFAs
 - c. EOBs
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 6-26-02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 6-28-02. The response from the insurance carrier was received in the Division on 7-10-02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of A letter Requesting Additional Information, is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 6-4-02:

"On 03/19/01, we received a prescription for the above named patient to receive a Hand/Wrist Cryo unit and on 03/26/01 we set up the patient.... After submitting our initial claim and also our request for reconsideration, the insurance carrier only paid us \$275.65 total for codes EO236 and EO249 out of \$620.00 that were billed for these items.

Per TWCC Medical Fee Guidelines, it clearly states that code E0236 should be paid at \$490.20 and since there is no MAR for code E0249 we have enclosed EOBs from other insurance carriers that have reimbursed us for this same code at the full amount. These EOBs should clearly prove and state that we are only asking to get reimbursed what is 'fair and reasonable' per our geographical area as TWCC Medical Fee Guidelines state.... In summary, we strongly feel and believe that we should be reimbursed an additional \$339.55 plus interest since it is clearly stated in the TWCC Medical Fee Guidelines or the EOBs clearly reflect what other insurance carriers are paying in our geographical area, [sic]".

2. Respondent: Letter dated 7-10-02:
 "The provider is billing for a water circulating pad and pump. By billing separately for these items instead of billing for the pad and pump, the provider is avoiding the preauthorization requirements for items over \$500.00. Documentation of medical necessity also fails to show the need for this expensive unit rather than an ice pack. Nevertheless, payment was issued to the provider at the fair and reasonable rate for these procedure codes as determined by ____ is collected regarding the amounts actually charged within a provider's area for specific procedure codes and tabulated to determine the current fair and reasonable rate for that charge in that particular area. Information is undated quarterly."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 3-26-01.
2. The carrier denied the billed services as reflected on the EOB as, "M – REDUCED TO FAIR AND REASONABLE"
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB	MARS	REFERENCE	RATIONALE:
3-26-01 3-26-01	E0236-NU E0249-NU	\$495.00 \$125.00	\$208.78 \$ 66.87	M M	DOP	MFG GI (VIII) (A); HCPCS descriptor	This modifier is not recognized in the Commission's '96 MFG. For this reason, MRD is unable to determine proper reimbursement for the services in dispute. Therefore, no reimbursement is recommended.
Totals		\$620.00	\$275.65				The Requestor is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 24th day of February 2003.

Lesa Lenart
 Medical Dispute Resolution Officer
 Medical Review Division

LL/ll